UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

RELENZA(zanamivir**)**

Patient name:_____Medicaid or SS#_____

Physician Name:_____ Contact person:_____

Phone#:_____Ext. and opt._____Fax#_____

Pharmacy_____Pharmacy Phone#:_____

All information to be legible, complete and correct or form will be returned

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TELEPHONE REQUEST OR WRITTEN REQUEST IN LETTER OF MEDICAL NECESSITY

CRITERIA:

- Age 13 years old and older
- Diagnosis of Influenza A or Influenza B
- Covered only for patients at high risk from diagnosed and documented disease states if immunodeficiency. The term "immunodeficient" includes: HIV/AIDS or other diseases that affect the immune system; long-term radiation treatment; long-term treatment with drugs such as steroids; oncology agents; immunosuppressive agents or fragility due to extreme age (greater than 65 years).

INFORMATION:

Dose: 10mg bid delivered via oral inhaler for 5 days

Limit: One box of 20 amps per year